ATA Operating Procedures for Pediatric Telehealth

(December 23, 2016)

PREAMBLE

The American Telemedicine Association (ATA), with members from the United States and throughout the world, is the principal organization bringing together telemedicine providers, healthcare institutions, vendors and others involved in providing remote healthcare using telecommunications (Turvey et al., 2013). ATA is a nonprofit organization that seeks to bring together diverse groups from traditional medicine, academia, technology and telecommunications companies, e-health, allied professional and nursing associations, medical societies, government and others to overcome barriers to the advancement of telemedicine through professional, ethical and equitable improvement in healthcare delivery. ATA has embarked on an effort to provide practice guidance and technical recommendations for telemedicine. The goal of this effort is to advance the science of telemedicine and promote the delivery of quality medical services. This guidance, which is based on clinical and empirical experience, has been developed by work groups that include experts from the field and other strategic stakeholders, including clinicians, administrators, technical experts, and industry leaders. This guidance has been designed to serve as an operational reference and an educational tool which will help provide appropriate care for pediatric patients. The guidance and recommendations generated by ATA undergo a thorough consensus and rigorous review, with final approval by the ATA Board of Directors. Existing guidance and recommendations are reviewed and updated periodically. The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. Accordingly, it should be recognized that compliance with this guidance will not guarantee accurate diagnoses or successful outcomes with respect to the treatment of individual patients, and ATA disclaims any responsibility for such outcomes. This guidance is provided for informational and educational purposes only and does not set a legal standard of medical or other health care. It is intended to assist providers in delivering effective and safe medical care that is founded on current information, available resources, and patient needs. The practice guidance and technical recommendations recognize that safe and effective practices require specific training, skills, and techniques, as described in each document, and are not a substitute for the independent health professional judgment, training, and skill of treating or consulting providers. If circumstances warrant, a provider may responsibly pursue a course of action different from the guidance when, in the reasonable judgment of the provider, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidance. Nonetheless, a provider who uses an approach that is significantly different from this guidance is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued. Likewise, the technical and administrative guidance in this document does not purport to establish binding legal standards for carrying out telemedicine interactions. Rather, it is result of the accumulated knowledge

and expertise of the ATA work groups and intended to improve the technical quality and reliability of telemedicine encounters. The technical aspects and administrative procedures for specific telemedicine arrangements may vary with individual circumstances. These circumstances include location of the parties, resources, nature of the interaction. Telehealth encounters with children and adolescents are complicated by a number of issues such as age, specific services provided, and the rights of parents/legal representatives impacting consent, confidentiality, and privacy. Adherence to this guidance by any organization for any telehealth program or service does not constitute endorsement of that service or program by the ATA or any other organization that supports these guidelines.

1. SCOPE

These operating procedures cover the provision of health care by providers to children, from the time of birth through the legal age of majority, using telehealth, which includes both real-time and "store and forward" interactive technologies and mobile devices. This guidance may also be applied to young adults beyond the age of legal majority who continue to receive pediatric care, such as those with a chronic pediatric illness or disability. Healthcare providers include but are not limited to individual practitioners, group and specialty practices, hospitals and healthcare systems, triage or call centers, and other healthcare providers of telehealth services. The procedures do not address communications between healthcare professionals and patients and parent/legal representatives via short message service, e-mail, social network sites, online "coaching," or the use of telehealth for primary care when one provider connects to another provider. The procedures are classified into three levels of adherence based on review of relevant literature and expert opinion: "shall" indicates a required action whenever feasible and/or practical; "shall not" indicates a proscription of an action that is strongly advised against; and "should" indicates a recommended action without excluding others. "May" indicates pertinent actions that may be considered to optimize the telehealth encounter. These indications are found in bold throughout the document. The procedures do not specifically address telemental health care with pediatric and adolescent patients as these are covered in a separate ATA guideline. The procedures do not provide guidance on the diagnosis and treatment of specific conditions.

The use of mobile devices by patients and parent/legal representatives for telehealth services introduces a number of additional factors regarding patient privacy, confidentiality, parental consent, and patient safety. Complete guidance for the safe and secure use of mobile devices for telehealth encounters is beyond the scope of this document. Telehealth services incorporating the use of mobile devices **shall** follow HIPAA privacy and security regulations and existing guidance specific to the state in which they practice and the state in which the patient is located. (Refer to Section 4.3)

ATA urges health professionals using telehealth in their practices to familiarize themselves with the guidelines, position statements, and recommendations from their professional organizations/societies and incorporate them into telehealth practice. While these operating procedures are written with a focus on care provided when both the provider and the patient are located in the United States the general tenets

are applicable to all pediatric telehealth.

The use of Electronic Health Records (EHRs) falls outside the scope of this document, except in the event that a pediatric virtual visit is initiated from within an EHR, Health Information Exchange (HIE), or patient portal, which does qualify as a pediatric telehealth encounter.

2. INTRODUCTION

Children represent one of our most vulnerable populations, and as such, require special considerations when participating in telehealth encounters. Some services provided to adult patients by telehealth may not be easily adapted to or appropriate for pediatric patients due to physical factors (patient size), legal factors (consent, confidentiality), the ability to communicate and provide a history, developmental stage, unique pediatric conditions, and age-specific differences in both normal and disease states (AHRQ, n.d.; Alverson, 2008).

These operating procedures for pediatric telehealth aim to improve the overall telehealth experience for patients, providers, and patient families. These operating procedures do reference general telehealth operating principles that apply beyond pediatrics and that warrant particular emphasis, but they are not meant to serve as a comprehensive stand-alone guide to the development and operation of a telemedicine service. ATA has developed and published core standards for telehealth operations that provide overarching guidance for clinical, technical and administrative standards (ATA, 2014a). The Pediatric Operating Procedures complement existing professional organization guidance from the American Academy of Pediatrics, American Psychological Association, the American Association of Family Physicians and the Society of Adolescent Health and Medicine.

3. PATIENT PRIVACY AND CONFIDENTIALITY (AAP, 2012; FTC, 2016; USDHHS, 2015a; USDHHS, 2015b; USDHHS, 2016a; USDHHS,2 016b)

1. Providers **shall** comply with all federal and individual state laws and regulations regarding child privacy, including but not limited to COPPA, HIPAA, HITECH and FERPA. All existing laws and regulations regarding patient privacy and confidentiality, including laws pertaining to protection of privacy when minors consent for their own health care, apply to telehealth encounters just as they do for traditional encounters; however, there may be additional language specifically for security of patient privacy and confidentiality when care is delivered via telehealth.

2. Policies and safeguards (technical, administrative, procedural, and environmental) **shall** be in place to protect patient privacy. If the provider is unable to maintain appropriate privacy during the encounter, due to factors on either the patient or provider side, the provider **should** consider terminating and/or referring the patient to another location.

3. If any telehealth encounter is to be recorded, providers **shall** be aware of state-specific laws regarding the recording of private conversations, and **shall** disclose to the patient and parent/legal representative that the encounter will be recorded and receive written consent for the recording. Providers **shall** be able to produce a copy of the recording for the patient/family upon their request in a timely manner and in accordance with their organizational policies (Rodriguez, et al., 2015).

4. The transmission of medical images, particularly photographs, from one provider to another for the purpose of providing or coordinating patient care falls within the scope of telehealth practice. Any patient images **shall** be sent via secure, encrypted means of communication, and **shall** comply with all state and federal laws regarding the transmission of those images. The transmission of pediatric patient images, in particular, represents a special situation which is subject to numerous state and federal regulations regarding both private health information and child privacy (ATA, 2014b).

3.1. Informed Consent

1. Prior to the initiation of a telemedicine encounter, except in the case of emergency, the provider or designee **shall** inform and educate the patient and/or legal representative about the nature of telemedicine service compared with in-person care, billing arrangements, and the relevant credentials of the distant site provider. The provider or designee **should** also include information about the timing of service, record keeping, scheduling, privacy and security, potential risks, mandatory reporting, and billing arrangements. Providers **should** consider whether consent for care is based on a specific condition, episode of care or a period of time. The information **shall** be provided in simple language that can be easily understood by the patient and/or legal representative. The provider **shall** follow state-specific requirements for the use of translation services for consent, and the provider **may** utilize translation services as necessary for consent in the absence of such state-specific requirements. These considerations are particularly important when discussing technical issues like encryption or the potential for technical failure. As with in-person care, providers **should** also make an effort to obtain the assent of pediatric patients participating in telehealth services in a manner appropriate to their understanding. (ATA, 2014a; NCSL, 2015).

2. *Age of Consent:* The age at which a person may lawfully consent to care can vary with the health condition at issue, the person's state of residence, or the state where the patient is at the time of the telemedical visit. Minors in all states have the right to consent to testing and treatment for a sexually transmitted disease (STD). In many states, minors also have the right to consent to: outpatient treatment for mental health issues; prenatal care; contraceptive services; and/or alcohol and substance abuse. The age of consent for these various conditions can vary not only among states, but also within a given state. For example, in one state the age of consent is 12 years for treatment for an STD and 14 years for substance abuse. The provider **shall** be aware of each state's rules in which the patient is physically located for that visit. In certain environments additional elements of consent **may** need to be considered (Guttmacher, 2016).

3. *Patient Verification:* Verification of providers and patients **should** follow the ATA Core Operational Guidelines. Pediatric patients **may** be verified by patient site presenters that may or may not be the parent and or legal representative. Providers **shall** make appropriate effort to confirm that patient receiving the services is the appropriate person (ATA, 2014a).

4. *Emergency Services*: In certain limited emergency situations, as with in person care, the informed consent requirement **may** be waived. A health care professional's decision to treat combined with parental consent and patient assent (when appropriate) is the preferred scenario for the provider working in a medical emergency. When any one of those factors is absent or unclear, the health care provider **shall** be (1) knowledgeable of state and federal laws related to a minor's right (or lack thereof) to consent for testing and treatment and (2) prepared to confront the ethical challenges surrounding those same issues.

3.2. Special Considerations & Environments

1. School Health Services

1.1. School Health Services: When a school system directly contracts with a health care provider or the provider is employed by the school system, FERPA regulations **shall** apply to confidentiality and privacy issues (USDE, 2015). Both HIPAA and FERPA regulations may apply to telehealth encounters that occur in schools, and specific policies for these services **shall** be developed at the local level through memorandums of understanding or other contractual arrangement between the health care provider and the school system.

1.2 There is a wide range of staffing models for School Health Services, which impacts how telehealth services can and should be provided in a school setting (NASN, 2012). Comprehensive guidance on the intersection between school health services and telehealth is beyond the scope of his guidance. However, specific guidance on school-based telehealth services **should** be developed.

2. School Based Health Centers (SBHC) (SBHA, n.d.)

2.1. Prior to the initial SBHC telemedicine encounter, parents/legal representatives **shall** sign consent forms allowing students to be seen and treated. Medical history and medical home information **should** be obtained at this time. The scope of telehealth services provided at the specific SBHC **should** be outlined in the enrollment forms and considered a part of the services provided by the SBHC. Parental involvement in visits **should** also be outlined in this document.

2.2. In addition to the signed consent, the telehealth presenter **should** attempt to gain verbal consent before any encounter occurs.

2.3. Parents **should** be allowed to participate in the encounter.

2.4. School-based Health Centers face additional privacy challenges due to the intersection of HIPAA and FERPA regulations (USDE, 2015; USDHHS, 2016).

2.4.1. School nurses and their records are governed by FERPA (USDE, 2015).

2.4.2. Clinical care provided in a school-based health center is covered by HIPAA (USDHHS, 2016).

2.4.3. When information needs to be shared between the school and the SBHC written parental consent outlining what information may be shared and why it will be shared **shall** be obtained. Such situations include: 1) The school nurse serving as the telehealth presenter. 2) Informing the school of a

child's diagnosis and his/her ability to return to class. 3) Collaborating with school employees to effectively treat a condition (e.g. discussing the efficacy of ADHD medications with a classroom teacher).

2.4.4. SBHC personnel **shall** understand the intersection of HIPAA and FERPA in the context of patient care (USDHHS, 2008).

3. Abuse

3.1. In the evaluation of child abuse and or sexual abuse, state child protective rules supersede individual HIPAA and FERPA regulations for consent.

3.2. Images captured in this environment **shall** follow Store and Forward guidance for safety, security, privacy, storage, and transmissions as well as institutional policies.

4. On Demand Primary and Urgent Care Services

4.1. Primary and urgent care telehealth services initiated on demand by the patient or legal guardian represent a unique application of telehealth. In many or most cases with such services, these encounters occur with no healthcare provider at the patient's location to facilitate the interaction between the patient and provider. As such, these encounters present unique challenges with respect to many aspects of the telehealth encounter that are addressed in this document, including informed consent, privacy considerations, technical quality, examination capabilities, coordination with the PCMH, and mechanisms for follow up.

4.2. The ATA has released Practice Guidelines for Live, On Demand Primary and Urgent Care (ATA 2014b), which do not fully address all pediatric considerations. Because pediatric patients represent a special population, additional guidance on the delivery of on demand primary and urgent care telehealth services to pediatric patients **should** be developed. Additionally, guidance for the use of on demand primary and urgent care services for the diagnosis and management of specific conditions in pediatric patients **should** be developed.

4.3. Peripheral examination devices for use in the home or other non-traditional care setting are an emerging technology. However, further study of the accuracy and effectiveness of these devices is required before any recommendations can be made regarding their use.

4. PATIENT SAFETY

1. Providers **shall** comply with relevant standards for each clinical situation, as determined by state medical boards and regulatory agencies in both the state where the provider is located and the state where the patient is located, just as they would for an in-person encounter. The provider **shall** have enough evidence from the history, physical exam and/or an established prior patient relationship to make an appropriate clinical decision. If the provider is unable to comply with the standard of care for diagnosis and management in any clinical situation, due to technical limitations or provider comfort level, the provider **shall** refer the patient for additional evaluation where they can receive the appropriate standard of care, whether that is an in-person encounter or a telehealth encounter that is not subject to the specific limitations.

2. Providers of telehealth **shall** meet the same standards for communication between patient and provider, and between provider and other organizations (including the PCMH), as those for in-person encounters, including a mechanism for any needed follow up after the conclusion of the encounter.

3. For inpatient and emergency department consultations, the telehealth provider **shall** make available relevant clinical reports to the originating site in a timely manner in a format that the originating site can incorporate into the patient's medical record.

4. The presenter or their designee **should** have the ability to gather, securely store, and securely transmit all required data prior to or at the time of the encounter, including but not limited to consents, demographics, and/or patient vital signs.

4.1. Parental/Legal Representative Presence

1. Except when telehealth is provided as a means of managing certain limited pediatric medical emergencies, telehealth providers **shall** have a mechanism in place (e.g., contact information to allow immediate contact with parent/legal representative in the event of an emergency and for prompt communication with the results of the encounter) to communicate with the parent or legal representative of a minor patient before a telehealth encounter (AAP, 2011a). See Patient Privacy and Confidentiality and Informed Consent sections for additional guidance on information to be provided, patient privacy, and age of consent.

2. A parent/legal representative **may** participate in the encounter either in person or remotely, unless the pediatric patient is legally authorized to consent to his/her own care.

2.1. If a parent is not physically present at the originating site, and would like to participate in the examination, the option to join **may** be put in place to allow the parent to participate, i.e. telephone, multipoint video, etc.

3. If the parent is present during an examination, whether in person or remotely, there **shall** be provisions in place to confirm that parents/legal representatives leave the room during confidential parts of the history and examination, as directed by state-specific guidelines for minor confidentiality, the provider's discretion and the nature of the visit.

3.1. If the parent or legal representative is asked to leave and is unwilling, the provider **should** be prepared to address the unwillingness and/or end the visit. In some cases, the pediatric patient may feel uncomfortable without the parent or legal representative present or request that the parent or legal representative remain in the room. This **should** be addressed similar to in person visits. (AAP 2011b)

3.2. In cases where a telepresenter is present for the encounter, the telepresenter can help confirm appropriate privacy for the patient including asking and assisting the parent/legal representative in leaving the room or suspending their participation in the encounter electronically and bringing them back or calling them back at the appropriate time.

4. The provider **may** document the participants in the encounter, and **should** document any participant's

refusal to leave the room when requested.

4.2. Emergency Contingencies

1. All telehealth services **should** include a triage plan to assess if the encounter is appropriate for the capabilities of that telehealth service, and a mechanism in place to refer the patient to an appropriate provider in the event that telehealth is determined not to be appropriate at any point during the encounter.

2. All telehealth services **shall** include an established emergency response plan in place for all telehealth encounters which is consistent with the capabilities of the originating site and utilizes the established emergency protocols at that location (AAP 2007).

3. Appropriate emergency supplies to intervene in the event of an unexpected emergency situation **shall** be available. Appropriate emergency supplies can vary depending on type of location, patient population, and type of encounter (AAP 2007).

4. In the event of an emergency, the telehealth provider **should**, if safe and feasible, stay on-line with the patient until transfer of care can be given to the team assuming care.

4.3. Mobile Devices

1. Additional concerns for the use of mobile devices by providers for the provision of telehealth services include:

1.1. Mobile devices used for clinical purposes **shall** require authentication for access to them, as well as timeout thresholds and protections when lost or misplaced. Mobile devices **should** be kept in the possession of the provider when traveling or in an uncontrolled environment. Unauthorized **persons shall not** be allowed access to sensitive information stored on the device or use the device to access sensitive applications or network resources. Providers **should** have the capability to remotely disable or wipe their mobile device in the event it is lost or stolen.

1.2. When using a mobile device (including laptops, tablets, cellphones and other devices), the provider **should** use cameras and audio equipment which meet the standards outlined in the ATA Core Guidelines (ATA, 2014a). Devices **shall** have up-to-date antivirus software and a personal firewall installed. Providers' portable devices **should** have the latest security patches and updates applied to the operating system and any third-party applications.

1.3. Applications used on mobile devices **should** be verified as medical grade and secured in accordance with existing privacy guidelines. Providers **should not** participate in telehealth services utilizing mobile devices unless they are certain that the applications and technology conform to the same security and privacy standards that apply to all telehealth devices.

1.4. In the event that mobile device videoconferencing applications allow multiple concurrent patient encounters to be open simultaneously, providers **shall** be aware of the potential security, privacy, and

confidentiality risks created by those applications, including inadvertent disclosure of protected health information and safeguard against those risks.

1.5. Patient images **should not** be sent via standard texting applications on mobile devices.

1.6. Providers **should not** store medical images on personal mobile devices. Images of children may be subject to specific regulations related to privacy and sharing. Particular care **shall** be taken to provide confidentiality and appropriate chain of custody of these images, especially for photo documentation of cases of child abuse.

1.7. Image resolution projected on a device **shall** be adequate for diagnosis (ATA, 2014a).

1.8. Please refer to ATA Core Telehealth Guidelines for additional guidance on the use of mobile devices for telehealth services (ATA, 2014a).

5. CLINICAL ENCOUNTER

1. Telehealth encounters **shall** be structured with consideration to privacy, consent and environments as outlined elsewhere in these operating procedures.

5.1. Equipment

1. Equipment used for provision of pediatric telehealth services **should** be appropriate to the age, size, and developmental stage of the child, including size, comfort, accuracy, and validity of measurements.

2. Telehealth services **shall** follow relevant standards for the diagnosis and management of any condition addressed, as determined by state medical boards and regulatory agencies in both the state where the provider is located and the state where the patient is located. The standards are the same for telehealth services as for in-person services. In cases where the standard of care includes the use of specific examination devices or tests for diagnosis, then these devices and tests **shall** either be utilized in the telehealth encounter, or the provider **shall** refer the patient to a provider or location with access to the necessary examination or testing devices so that the patient can be appropriately evaluated prior to the prescription of medications or other treatment for the management of that condition (NABP, n.d).

3. For any telehealth encounter, there **shall** be at least one party to the encounter who is capable of operating all involved equipment in accordance with the specifications for the use of that equipment. Providers **should** be aware that the use of some equipment in children may pose unique challenges relating to patient cooperation, size, comfort, and technique, and should be comfortable with the use of all involved equipment in children. Providers **shall** determine whether the quality of the device output and displayed images are sufficient for the diagnosis and/or management of the patient's condition.

4. Telehealth providers **shall** have a technical support plan and contingency plan in place in the event of technology or equipment failure during an encounter.

5. Telehealth equipment and telecommunications **should** comply with medical grade security regulations and encryption guidelines. Refer to Core Operational Guidelines for Telehealth Services-Technical

guidelines.

6. Telehealth providers **may** consider use of headphones on both the patient and provider side of the consultation to improve patient privacy, provided this does not interfere with parent/legal representative interaction or facilitator presence during the encounter.

5.2. Environment

1. At the telehealth provider site:
    1.1. The provider **shall** minimize distraction, background noise and other environmental conditions that may affect the quality of the encounter
    1.2. The environment **shall** meet standards for privacy and confidentiality
    1.3. Personal health information not specific to the patient being examined **shall** not be visible
    1.4. The provider **shall** guide the patient or facilitator as needed on means of providing privacy at the patient end.
    1.5. The provider **shall** have a process for verifying who is present on the patient end and who joins or leave the encounter

2. At the patient site:
    2.1. The patient or facilitator **should** identify an appropriate space for the patient encounter. Ideally the space **should** be large enough to comfortably accommodate the patient, up to two parents or legal representatives, and a telepresenter, along with necessary examination equipment. If present, the parent/legal representative **should** also be able to see any monitors or clinical information that is visible to the patient, and to be seen on camera by the remote provider. Such spaces **should** be compliant with the American Disability Act and the recommendations from the ATA's telepresenting guidelines.
    2.2. The patient or facilitator **should** make the telehealth provider aware of all persons present on the patient end and notify the provider of anyone who enters or leaves the encounter
    2.3. No personal health information not specific to the patient being examined **should** be visible

5.3. Presenters and Facilitators (ATA 2011)

1. See the American Telemedicine Association Expert Consensus Recommendations for Videoconferencing-Based Telepresenting (ATA 2011) for more detailed guidance on telepresenting and facilitation. Telehealth providers **should** provide training for telepresenters and telefacilitators consistent with this or other comparable guidance.

2. Clinical Patient Presenters
    2.1. The provider **shall** determine if the telehealth encounter is appropriate for diagnosis and management of specific clinical conditions. This includes the qualification and skill of the presenter.
    2.2. In a clinical setting, the presenter **shall** be trained on how to manage a telehealth encounter, including how to share all required documents to the provider in a HIPAA compliant manner.
    2.3. Presenters **should** be trained on the use and limitations of pediatric specific equipment

2.4. The presenter **should** facilitate the introduction of all parties present for the encounter.

2.5. In a clinical setting, if a presenter is asked to leave the room, the presenter **should** instruct the patient/parent/legal representative on how to notify the presenter to reenter the encounter.

3. Non-Clinical Facilitators

3.1 The provider **shall** determine if the telehealth encounter is appropriate for diagnosis and management of specific clinical conditions. This includes the qualification and skill of the facilitator.

3.2 Providers **should** be aware that facilitators may not be clinically trained. Therefore, any patient data **should** be considered self-reported.

3.3. It **may** be the responsibility of the facilitator to facilitate introduction of all parties present for the encounter.

5.4. Provider Considerations

1. Through the use of telehealth, providers can provide appointment flexibility, increase access, promote continuity of care, and improve quality, either as a part of or as a complement to care delivered through the patient-centered medical home (PCMH). Whether telehealth services are delivered through the PCMH or as a complement to it, telehealth providers **should** routinely communicate with a patient's primary care provider and any relevant specialists regarding a telehealth encounter. Telehealth providers **shall** have a standard mechanism in place to share secure documentation of the encounter with the PCMH (AAP, 2015) in a timely manner.

2. Providers **should** only provide services to pediatric patients via telehealth within the scope of their appropriate practice for in person encounters. Providers **shall** have the necessary education, training/orientation, licensure, and ongoing continuing education/professional development, in order to command the necessary pediatric knowledge and competencies for safe provision of quality pediatric services in their specialty area (ATA, 2014a).

3. Telehealth providers **shall** maintain professional licensure to practice in the state in which the patient is located at the time of the telehealth encounter (ATA, 2014).

4. Telehealth providers **shall** be credentialed and privileged to provide pediatric services in accordance with local, state, and federal regulations at both the jurisdiction (site) in which they are practicing as well as at the jurisdiction (site) in which the patient is receiving care.

5. Providers **shall** follow relevant practice guidance developed by the specialty societies as they relate to both in-person and telehealth practice.

6. When diagnostic exams or tests are ordered, the provider or their designee **shall** follow up on the results, share with the patient/family and the patient-centered medical home/primary providers, as well to treat or refer patient based on results.

7. All participating providers in a telehealth entity or organization **shall** be appropriately supervised for their specific scope of practice, in accordance with local, state, and federal regulations. Supervisors are also considered telehealth providers for the purposes of these operating procedures.

8. The provider or designee **shall** set appropriate expectations regarding the telehealth encounter, including, for example, prescribing policies, scope of service, communication, and follow up. To reduce the risk of overprescribing, the provider **shall** follow evidence-based guidelines and all federal, state, and local regulations. Prescribing in connection to a pediatric telehealth encounter is not equivalent to online pharmacy services *per se*. However, telehealth providers who are prescribing **shall** be familiar with the federal Controlled Substances Act (CSA) (United States Code Title 21) and other relevant state and federal regulations (USDEA, 2009).

6. LEGAL AND REGULATORY CONSIDERATIONS

1. Providers **shall** follow federal, state, and local regulatory and licensure requirements related to their scope of practice and shall abide by state board and specialty training requirements.

2. Providers **shall** practice within the scope of their licensure and shall observe all applicable state and federal legal and regulatory requirements.

3. Providers **should** be aware if the patient is physically located in a jurisdiction in which the provider is duly licensed and credentialed. Providers **should** document the patient's physical location at the time of the telehealth encounter. If the patient is not located at a known originating site, then the provider **should** document the patient's stated location in the medical record.

4. Special considerations that may vary by state for pediatrics include, but are not limited to: consent, parental presence, requirements for establishing a physician-patient relationship, prescribing, prescribing controlled substances, handling of images, and age of majority.

7. REFERENCES

Agency for Healthcare Research and Quality. (n.d.) Draft Technical Brief. Telehealth: An evidence map for decision-making. Rockville, MD. Available at: http://www.effectivehealthcare.ahrq.gov/ehc/products/624/2160/telehealth-draft-report-151209.pdf

Agency for Healthcare Research and Quality (2016). Defining the PCMH. Available online at https://www.pcmh.ahrq.gov/page/defining-pcmh

Alverson, D.C., Holtz, B., D'Lorio, J., DeVany, M, Simmons, S., & Poropatich, R.K. (2008). One size doesn't fit all: Bringing telehealth services to special populations. *Telemedicine and e-Health,* 14(9), 957-963.

American Academy of Pediatrics (2002). The Medical Home: Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Pediatrics Jul 2002, 110 (1), 184-186

American Academy of Pediatrics. (2007). Preparation for emergencies in the offices of pediatricians and pediatric primary care providers. *Pediatrics,* 120(1), 200-212.

American Academy of Pediatrics. (2011a). Consent for emergency medical services for children and adolescents. *Pediatrics,* 128(2), 427-433.

American Academy of Pediatrics. (2011b). Use of Chaperones During the Physical Examination of the Pediatric Patient. Committee on Practice and Ambulatory Medicine. *Pediatrics,* 127(5), 991-993.

American Academy of Pediatrics. Committee on Adolescence, Council on Clinical and Information Technology (2012). Standards for Health Information Technology to Ensure Adolescent Privacy. *Pediatrics*, 130(5), 987-990.

American Academy of Pediatrics. (2015). The use of telemedicine to address access and physician workforce shortages. *Pediatrics,* 136(1). Available at: http://pediatrics.aappublications.org/content/pediatrics/136/1/202.full.pdf

American Telemedicine Association. (2011). Expert Consensus Recommendations for Videoconferencing-Based Telepresenting. Available at: http://www.americantelemed.org/docs/default-source/standards/expert-consensus-recommendations-for-videoconferencing-based-telepresenting.pdf?sfvrsn=4

American Telemedicine Association. (2012). "What is telemedicine?" Available online at http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VtS4pxi2iTU

American Telemedicine Association. (2014a). Core operational guidelines for telehealth services involving provider-patient interactions. Available at: http://www.americantelemed.org/docs/default-source/standards/core-operational-guidelines-for-telehealth-services.pdf?sfvrsn=6

American Telemedicine Association (2014b). Practice guidelines for live, on demand primary and urgent care. Available online at: http://www.americantelemed.org/docs/default-source/standards/primary-urgent-care-guidelines.pdf?sfvrsn=4

Burke, B.L., & Hall, R.W. (2015). Telemedicine: Pediatric applications. *Pediatrics. 136(1).*

Federal Trade Commission. (2016). Children's Online Privacy Protection Rule (COPPA). Available at: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=34:1.1.1.1.33

Guttmacher Institute. (2016). State Center. Available at: https://www.guttmacher.org/statecenter/

National Association of Boards of Pharmacy. (n.d.) Standards. Available at: http://www.nabp.net/programs/accreditation/vipps/standards

National Association of School Nurses (2012). The Use of Telehealth in Schools. Available at: http://www.nasn.org/Portals/0/positions/2012pstelehealth.pdf

National Conference of State Legislatures. (2015). Telehealth policy trends and considerations. Available at: http://www.ncsl.org/documents/health/telehealth2015.pdf

Rodriguez, M., Morrow, J., & Seifi, A. (2015). Implications of Patients and Families Secretly Recording Conversations With Physicians. *JAMA*, 313(16):1615-1616.

School Based Health Alliance (n.d.) Core Competencies. Available at: http://www.sbh4all.org/resources/core-competencies/

U.S. Department of Education (2015). Family Educational Rights and Privacy Act Regulations (FERPA). Title 34: Education. Part 99-Family Educational Rights and Privacy. Available at http://www2.ed.gov/policy/gen/reg/ferpa/index.html

U.S Department of Health and Human Services. (2008). Joint guidance on the application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to student health records. Available at: http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf

U.S Department of Health and Human Services. (2015). Health IT Legislation: HITECH Act. Available at: https://www.healthit.gov/policy-researchers-implementers/health-it-legislation

U.S. Department of Health and Human Services. (2016a). Summary of the HIPPA Privacy Rule. Available at: http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

U.S. Department of Health and Human Services. (2016b). Summary of the HIPPA Security Rule. Available at: http://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

U.S. Drug Enforcement Agency (2009). Implementation of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. *Federal Register,* 74(64). Available at http://www.deadiversion.usdoj.gov/fed_regs/rules/2009/fr0406.pdf

8. DEFINITIONS

1. Telehealth: Broad term for remote healthcare including clinical services, tele-education, teleresearch, and other non-clinical applications. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.

2. Telemedicine: The use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Telemedicine is typically considered a subset of telehealth services.

3. Originating Site: Location of the patient receiving a telemedicine service. Telepresenters may be needed to facilitate the delivery of this service. Other common synonyms include spoke site, patient site, remote site, and rural site, access site.

4. Distant Site: Site at which the provider delivering the service is located at the time of the telehealth service. Other common synonyms include hub site, specialty site, provider/physician site, referral site and consulting site.

5. Facilitator: An individual who may or may not have a clinical background who is present with the patient during a telemedicine encounter. Responsibilities may vary with practice site, but may include scheduling, organizing, executing the connection and/or patient presenter functions. Examples may include a clinical provider, support staff or parent/legal representative.

6. Presenter (Patient Presenter, Telepresenter): An individual with a clinical background trained in the use of telehealth equipment who may be available at the originating site to manage the cameras and perform any “hands-on” activities to complete the tele-exam successfully. Examples include: RN, RRT, LPN, CNA, MA.

7. Protected Health Information (PHI): Part of the HIPAA Privacy Rule that protects all "patient identifiable information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI).” “Patient identifiable information” is information, including demographic data, that relates to the individual’s past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). The Privacy Rule excludes from protected health information employment records that an employer maintains and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g (USDE, 2015; USDHHS, 2016).

8. Store-and-Forward Telemedicine: Transmission of stored digital images or diagnostic studies across a distance for diagnosis or management of medical conditions. Synonyms include Image Enhanced or Asynchronous Telemedicine.

9. Videoconference-Enhanced Telemedicine Visit. Use of real-time videoconferencing between sites to provide medical care to a patient.

10. Minor: A person who has not attained the age of majority or met other criteria for majority specified in the applicable State law, or if no age of majority or other applicable criteria are specified in the applicable State law, the age of eighteen years.

11. The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education (USDE, 2015).

12. School-based health services: Telehealth can be used to provide a variety of services in the school setting. School health services include health education, school nursing, medical evaluations, and health services such as speech therapy, oral health, physical therapy or mental health counseling. School-based health centers (SBHC) are clinics that are located in or near a school facility and are administered by a sponsoring facility. The sponsoring facility may include a hospital, public health department, community health center, nonprofit health care agency, or local educational agency. For the purpose of this guidance, pre-kindergarten education or child care settings are not considered a school setting.

13. Children's Online Privacy Protection Rule (COPPA) (15 U.S.C §§ 6501 – 6506 (Pub.L. 105-277, 112 Stat. 2681 – 728) is a federal law that governs the online collection of personal information from children under 13 years old, including what a website operator must include in a privacy policy and when and how to seek verifiable consent from a parent or legal representative (FTC, 2016).

14. Health Insurance Portability and Accountability Act (HIPAA) (Pub.L. 104 – 191, 110 Stat. 1936) is federal legislation with multiple components relating to health care insurance portability, electronic health records, and patient privacy. The HIPAA Privacy Rule regulates the use and disclosure of Protected Health Information (PHI) (USDHHS, 2016). The HIPAA Security Rule regulates the electronic storage and transmission of PHI. (USDHSS, 2016b).

15. Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111 – 5) to promote the expansion of Health Information Technology (HIT), including provisions for Meaningful Use, privacy, security, and testing (USDHHS, 2015).

16. Patient-Centered Medical Home (PCMH): A medical home is an approach to providing comprehensive and high quality primary care. A medical home should be the following:

- **Accessible:** Care is easy for the child and family to obtain, including geographic access and

insurance accommodation.

- **Family-centered:** The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family. **Continuous:** The same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care.
- **Comprehensive:** Preventive, primary, and specialty care are provided to the child and family.
- **Coordinated:** A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.
- **Compassionate:** Genuine concern for the well-being of a child and family are emphasized and addressed.
- **Culturally Effective:** The family and child's culture, language, beliefs, and traditions are recognized, valued, and respected

A medical home is **not** a building or place; it extends beyond the walls of a clinical practice. A medical home builds partnerships with clinical specialists, families, and community resources. The medical home recognizes the family as a constant in a child's life and emphasizes partnership between health care professionals and families. (AAP 2002) A variety of telehealth services can be provided through or coordinated through the patient-centered medical home. Procedures for communication and coordination with the patient-centered medical home are described above.

17. Consent: Permission to proceed with an encounter, test, or treatment from a patient or parent/legal representative who has health care decision making authority for the patient.

18. Assent: Agreement from the patient to proceed with an encounter, test, or treatment, regardless of whether the patient has health care decision making authority.

19. In-Person Care: Services provided when the patient and provider are together in the same physical location for evaluation, diagnosis, and/or management.